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AUTHOR Birney, David
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ABSTRACT

This paper describes a program that links a community mental health center and a rural education cooperative for the provision of psychological services to children experiencing emotional/behavioral problems. The program description provides background information and lists reasons for selecting a flexible problem-solving consultee-centered format that: (1) provides a practical field-based approach; (2) improves mental health knowledge and skill levels of school personnel; (3) favors an egalitarian emphasis; and (4) builds on the independent nature of consultees who want to solve their own problems. The variety of available intervention options and the extent of their utilization is also discussed. The difficulty in recruiting and keeping qualified staff in rural programs is noted and reasons for staffing the program with doctoral level school psychology interns supervised by a staff psychologist are explained. Utilization and evaluation outcomes of the program for the 1980-81 school year are presented in terms of entry into schools, caseloads, activity levels, presenting problems, interventions, acceptability, and success. Program weaknesses are also discussed along with possible solutions. (NRB)

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A Model for the Delivery of Psychological Services to Rural Schools

David Birney, Ph.D.
Unit Director
Mental Health Services of
Southern Oklahoma
Ada, Oklahoma

Presented at the 1981 Annual Convention
American Psychological Association

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A Model for the Delivery of Psychological Services
to Rural Schools

This paper describes a currently functioning program which links a community mental health center and a rural education cooperative for the purpose of providing psychological services to a previously unserviced population of children experiencing emotional/behavioral problems. The program is still developing and continues to change as more is learned each year. The area served is a rural county in South Central Oklahoma with a population of about 28,000. The largest town has a population of 6,000. The area is substantially poor and predominantly white. The economy is based on agriculture with some industry.

Background

The program was begun in 1978 in part as a response to P.L. 94-142. In addition, the local schools had recognized their limitations in adequately serving their students with emotional problems. Therefore they came to the community mental health center, then two years old, requesting help. However, the budget was limited. The response of the CMHC was to utilize currently employed clinically trained staff with no experience in a school setting. This proved to be a poor choice. A traditional clinical service model was adopted in which children were viewed as "cases" who were treated in a counseling office, to appear again "cured." Little help was provided to the referring teacher. Clinical staff seldom appeared on the school site. Counseling services were frequently refused by referred parents, resulting in some children receiving no services, though services were requested by the school. This approach led to high levels of dissatisfaction within the schools which eventuated in a threat to cancel the contract. In response, the program was redesigned to more realistically meet the needs of the schools.

Design Considerations

In redesigning the program, a number of factors needed to be considered which are characteristic of the area served, and characteristic of many rural areas around the nation.

First, the severe limitations of financial resources had to be recognized. This area is poor and has an extremely limited tax base. Therefore, the program needed to be designed to produce maximum impact for minimum cost.

Second, problems of geography existed. This county has a large number of people dispersed widely over a large area. There are no public or private transportation systems. Most travel is by automobile, using costly gasoline.

Third, there are few other community resources. Very little was available for helping children with emotional/behavioral problems. Existing programs have chronic manpower problems.

Fourth, local attitudes toward mental health were not totally positive. Though a few key school officials believed strongly in what we were doing, the general view toward mental health is one of healthy skepticism. Professionals are often considered to be rather dense and unhelpful (an attitude reinforced by previous services), and new people are outsiders and tend to stay in that role for extended periods.

Fifth, school personnel had limited knowledge of mental health principles and techniques. In addition, there was a tendency to anticipate simple solutions to complex problems. Some potentially effective solutions were rejected entirely because they were not consistent with the value system of staff members.

Many of these factors were viewed negatively. However, other attributes were seen as strengths. The mental health system had a high level of acceptance with some powerful school officials. This was based on previous relationships among staff members, i.e., a member of the CMHC's staff had previously been a well-respected member of the school administration. This type of relationship is not unusual in rural areas and should not be left unrecognized. Secondly, there is a strong local emphasis on "taking care of our own," and solving the problems which are presented, rather than just talking about them. Thirdly, the systems involved are physically accessible. The small size of the districts made it possible to meet and get to know key staff within a one day visit. Finally, though the schools knew what they wanted in general, they had few preferences in regard to design. This provided a great deal of freedom.

One final issue had to be given a very close look in the decision regarding program design. This involved staffing. Well trained professional staff are rare in rural areas, especially in towns under 5,000 population. Those who are willing to locate there frequently leave within a few years. They experience cultural conflicts and personal and professional isolation. They are outsiders no matter how long they stay. They become uncomfortable with the shortage of personal space. And they simply grow tired of the endless demands on their time, energies and loyalties. In addition to the demands, they need to "fit in" and change systems gradually, rather then fight injustice. Crusading outsiders are rarely successful in rural environments. In short, there is a very

limited pool from which to select staff. The program had to be designed with the anticipation of problems recruiting and keeping qualified personnel.

The Program

Responding to the issues raised above, a program was designed. An orientation toward the solving of most immediate problems was adopted which avoided diagnosis, labels, and excessive analyzing. It was felt that school personnel were vulnerable to misunderstanding of diagnostic categories due to unfamiliarity with mental health concepts, and might infer a disease model suggesting "incurability." It was also felt that this concrete problem solving approach would be most congruent with local preferences.

Also, a decision was made to make the program almost entirely field based, due to severe transportation problems. In addition, mental health professionals were sometimes viewed as different, distant and rather elitist. Professional staff making the effort to go to the client might, and in fact did, promote mutual respect and co-equality. Also, there appeared to be low motivation for school personnel to deal with the unfamiliar mental health system. Experience indicated that the clinic-based approach resulted in very uneven patterns of usage, with most clients coming from the immediate proximity. It was deemed crucial for schools from all over the county to have equal access to services.

A flexible consultee-centered mental health consultation format was selected as the heart of the program. Flexibility was a necessity because of shortages of alternative resources. If this program did not serve the child, it was unlikely that anyone else would. Therefore, the role could not be defined narrowly, but a clear direction toward a consultee centered approach was imposed. The consultee-centered orientation was selected for several reasons. First, it was the only practical field based approach. Responsibility for clients had to remain with school personnel because placing it anywhere else was logistically impossible. Clients were too widely dispersed to serve them directly. Secondly, in order for the schools to become more responsive to the needs of their students, mental health knowledge and skill levels needed to be improved. The consultee-centered approach has that capability. Thirdly, because there was considerable skepticism of outside experts in these systems, it was predicted that an expert model would encounter considerable resistance. The co-equal emphasis was designed to breakdown barriers. And finally, the consultees were independent, self-reliant people who wanted to solve their own problems. This was a strength to be built on and encouraged, and the consultee-centered approach could do this.

Although strong emphasis was placed on a consultee centered consultation approach, many other intervention modalities were available. Following initial assessment and consultation with school staff, treatment options included facilitation of coordination among other community resources, short term on-site counseling with the student and/or their families, referral to the CMHC for longer term counseling, in-service training for school staff, and as well as inpatient treatment for the referred student. The extent to which these options have been utilized is discussed later in this paper.

The program staff consists of a doctoral level intern from a school psychology training program, supervised by a doctoral level school psychologist already on the staff of the CMHC in an administrative position. The use of a student/intern rather than a permanent staff member was a deliberate choice. Interns are inexpensive and money was very tight. Interns are allowed to be flexible in their work habits, and therefore would be freer to respond quickly to requests for service. And also, the attitudes and behaviors of interns neutralize many of the key staffing issues described earlier. Because of the demands of the position, turnover rates were expected to be high. Rather than ignoring and bemoaning this fact, it was accepted that no person would do this job for more than one year. Therefore, little is lost in utilizing an intern on a one year internship. In fact, for that one year period the probability of stability is greater than with a "permanent" employee. Also interns are supervised closely, lessening the isolation that permanent staff feel. Interns view their work as a learning experience, have a different reward system (learning), and are therefore less vulnerable to fatigue and burnout. Finally doctoral students typically bring with them high levels of expertise and experience not often found in permanent staff, and are willing to learn, analyze and experiment in order to develop further. In this very complex and demanding work, such openness is essential.

Within the service delivery process, a strong emphasis on entry and gatekeeping issues was also built in. It was recognized and emphasized that each school served is different, has a different gatekeeping structure, and different key personnel. In addition the rural style of emphasis on one-to-one personal relationships was acknowledged. Considerable time and energy is spent on developing trust with key people. Experience indicates that once such relationships are established, complete entry goes much more smoothly. Conversely, if this time is not taken, entry is practically impossible. In short, it was decided to go slow, because it is the only way that works.

In summary, the new program adopted is a field based approach which emphasizes problem solving consultee-centered consultation, but includes a variety of intervention options. Most services are delivered by a doctoral level school psychology intern supervised by a doctoral level school psychologist. The program emphasizes the importance of entry at all levels of the system and takes optimal advantage of previously existing relationships.

Outcomes

The outcomes presented here reflect services during the 1980-1981 school term. So far during the 1981-1982 term, rate of service delivery has increased further.

Entry. Full entry was achieved in five of the nine school systems, and partial entry (some schools) in two additional systems. There were no meaningful contacts with the two remaining schools, which are most distant from the Cooperative's offices. Services appeared to be most acceptable at the elementary school level.

Caseload. Although many more children were discussed, significant interactions involved a total of thirty-five students, ranging in age from five to seventeen years old. Referrals appeared to cluster in certain age groups. Five referrals were six years old. Seven referrals were eight years old. Eight referrals were nine years old. And six referrals were thirteen.

Activity level. The number of consultant/consultee interactions regarding each referral ranged from one to ten. The mean was 3.9 interactions per referral.

Presenting problems varied very widely. Gross classifications are given below:

Acting out	11 referrals
Underachievement	7
School withdrawal	4
Stealing	3
Depression	3
Obesity	2

Other problems included child abuse, substance abuse, dependency, over-activity, effeminate behavior, family problems, Tourette's syndrome, delusional behavior.

Interventions. One hundred per cent of all referrals involved consultation with school personnel. Twenty-five per cent involved intervention with parents. Twenty-five per cent involved short term counseling with the consultant. Twenty-one per cent involved coordination with resources outside the school. Fifteen per cent involved referral to outpatient counseling. Nine per cent involved formal diagnostic testing. Three per cent were referred for inpatient treatment.

Acceptability. Acceptability was determined by a questionnaire distributed to all school personnel with whom contact was made. The return rate was a rather low thirty per cent. Raters were asked to rate the consultant on several dimensions on a one (low) to five (high) scale. Results follow:

Interpersonal Skills (warmth, empathy, listening)	4.88
Competence (knowledge, ability to help)	4.71
Professionalism (punctuality, demeanor, confidentiality)	4.94

A further indication of acceptability is the expansion of the contact for the 1981-1982 school term from one day per week to two days per week with a doubling funding.

Success. Rates of success were determined very subjectively by teacher report through the consultant. Seventy-four per cent of teachers reported significant improvement in their students referred. This statistic is obviously highly questionable though does give some support for the success of the program.

Discussion

The program developed appears to be working. Numbers of appropriate referrals continue to increase and almost all feedback, both formal and informal, is positive. However, there are serious weaknesses. Greater efforts are needed to enter outlying schools. This is being done this year. Also, a way to better serve high schools must be found. High school students with behavioral/emotional problems remain more frequently expelled than referred. Time has also become a problem. As acceptability grows, demand grows. The education cooperative is now receiving 3 days plus of services per week, but is contracting

for only two days. Because an intern is delivering the service, the CMHC can afford to donate the extra time, but it is problematical how long this can continue. Finally, and most importantly, more effective use of other formal and natural support systems needs to become an integrated part of the program. This is difficult because of staff turnover. Some better mechanisms of continuity need to be built in in order for these systems to be used optimally.